EDITORIALS

PSRO, Politics and Quality Assurance

IN THIS ISSUE of the journal, Alan R. Nelson offers both his impression of the Professional Standards Review Organization (PSRO) program's present illness and his guarded prognosis. As the founder of a prototype PSRO and charter member of the National PSR Council, Dr. Nelson has been a staunch advocate of PSRO as it was originally proposed by Senator Wallace Bennett. His informed commentary carries a clear message: PSRO has been progressively politicized around the issues of cost containment and public disclosure of PSRO data. This, together with numerous changes in the program's administration, has seriously jeopardized its future as a physicians' program of professional self-regulation in quality assurance.

Cost control generally is a paramount issue in the Congress and the executive branch of government, and this concern is focused particularly on the highly visible, widely publicized multibillion dollar expenditures under Medicare and Medicaid. This means that PSRO will continue to be viewed by Congress and the Department of Health, Education, and Welfare (DHEW) as an instrument for controlling those expenditures. Confrontations between the private sector of medicine and the government on this issue can at best only result in a standoff. The reason is that even when PSRO's do what they are expected to do—eliminate unnecessary hospital admissions and days of stay—there is no assurance that actual dollars will be saved.

The recent evaluation of PSRO performance by DHEW claimed that PSRO's were beginning to pay for themselves through savings of paper dollars, those assumed to have been saved as a result of reducing hospital use by Medicare and Medicaid patients.[1] However, a study of the Colorado PSRO by Private Initiative in PSRO* found no relationship between hospital utilization and hospital reimbursements by Medicare or Medicaid.[2] Specifically, in the Medicaid program, hospital use was *reduced* almost 12 percent in three years but hospital reimbursements *increased* 37 percent for the same period. Under Medicare, PSRO reviews kept the increase in hospital use to 12 percent in three years but actual reimbursements to those same hospitals for the same period went up 58 percent. The reason for the dissociation between utilization and expenditures is that the reimbursement of hospitals is negotiated by the fiscal intermediaries and the hospitals. PSRO's have no direct effect on the results of these negotiations, regardless of their effectiveness in controlling unnecessary hospital use. Consequently, attempts to prove that PSRO's are or are not "cost effective" come under the heading of political jousting, and it is not to be expected that the issue will be resolved rationally by objective and valid study.

The "assaults coming from the left," as Dr. Nelson puts it, pressing for publication of confidential physician data, will also predictably continue as a major symptom of another national issue surrounding PSRO's: explicit public accountability. There being no public representation on the National PSR Council that sets policy and reviews performance of PSRO's, public-interest groups are demanding access to profile data on physicians and hospitals. Whether such data can or cannot be released is under judicial review. If they were to be released, accurate interpretation would be difficult. The reliability and comparability of profile data have not been ascertained. Further, the data are greatly simplified and require additional clinical details for proper analysis.

Even if valid data on quality were available, impartial observers of PSRO would be hard put to attribute responsibility for the quality of hospital care to PSRO's. Dr. Nelson has posed the issue as "the delegated hospital emerging as the basic functional unit in most PSRO's" and the PSRO's "often being in an adversary position with the hospitals themselves." This situation is simply an inescapable fact of life, given the many court rulings that hospitals have a separate corporate responsibility for the quality of care. It seems

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unrealistic to expect PSRO's to preempt this responsibility, and the amount of physician support of PSRO's is clearly insufficient to enable PSRO's to supplant the medical staff as the body that implements programs of quality assessment and assurance on behalf of hospital boards.

What can be concluded from this array of issues? For certain, the future of PSRO will be decided politically, not rationally. Physicians should continue to support PSRO because it is far from certain in today's political climate that the medical profession would be given another comparable opportunity in self-regulation. Given the continuing pressures to restrain hospital use, Private Initiative in PSRO concluded that "PSRO's are necessary, legally institutionalized mechanisms for protecting Medicare and Medicaid patients from inappropriate and unwarranted restrictions on needed services. . . . Such an organization, composed of physicians capable of setting reasonable standards of care and promoting their attainment, is an essential concomitant of any program, public or private, directed to containing costs."[2]

It also is evident that the federal and state governments are now in permanent partnership with physicians and hospitals in "quality assessment and quality assurance." In recognition of this fact, Private Initiative in PSRO advocated a set of principles that defined the respective responsibilities of government and the private sector in shaping the future of quality assurance. These principles state that although DHEW is legally authorized to require an accounting of the necessity and quality of services paid for by the government, it is the primary responsibility of physicians and hospitals to devise and carry out programs with the intent of improving patient care and generating objective data by which to document the assurance of quality. These data should then be transmitted to DHEW and any other public, private or third-party purchaser of care, in fulfillment of their requirements that any service paid for by them must conform to the practicable standards of the providers. By this means, quality assurance mechanisms would become publicly accountable.

The function of PSRO in quality assurance is clearly limited to assuring a basic standard of care. Most PSRO's are not now capable of assessing hospital care at this minimal level and it is doubtful that many will acquire this capability in the near future. It is manifestly unrealistic to expect PSRO to become the principal vehicle for raising hospital care to the highest practicable standards. In keeping with the requirements of the Joint Commission on Accreditation of Hospitals, it remains the responsibility of medical staffs of hospitals to assure that all patients receive the technical quality of care made possible by the steadily increasing capabilities of medical science.

These observations in no way detract from the importance of the PSRO program as the means of satisfying legitimate demands for greater accountability in the face of continuously escalating expenditures of public funds for medical care. Given necessary financial support and professional direction, PSRO may still fulfill its intended societal function of assuring that all Medicare and Medicaid patients receive an acceptable quality of care provided in the most efficient manner permitted by local circumstances.

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REFERENCES

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Noninvasive Evaluation of Cerebrovascular Disease

ELSEWHERE in this issue, Carson and Blaisdell present an excellent, detailed and objective analysis of the current status of various noninvasive techniques available for evaluation of extracranial cerebrovascular disease. The technology of instrumentation is advancing at a tremendous pace, and it behooves one to consider carefully the role of noninvasive testing before embarking upon a very expensive program that uses instruments which may be outmoded before adequate clinical assessment of their performance can be made.

At present, patients with *symptoms* of cerebral ischemic episodes require contrast arteriography for proper planning of therapy, especially carotid endarterectomy. Noninvasive examinations, although interesting, are not essential. Arteriography is still the definitive diagnostic procedure, and will